STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005006	A. BUILDING _____ B. WING _____	09/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA UNIVERSITY HEALTH LA PORTE HOSPITAL	1007 LINCOLNWAY LA PORTE, IN 46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for investigation of two State hospital complaints. Complaint Number: IN00108952 Unsubstantiated: No deficiencies cited. Complaint Number: IN00113458 Unsubstantiated: No deficiencies cited. Date: 9/26/12 Facility Number: 005006 Surveyor: Jacqueline Brown, R.N., Public Health Nurse Surveyor Indiana University Health LaPorte Hospital is in compliance with 410 IAC 15-1.6-2, Emergency services, 410 IAC 15-1.6-5, Psychiatric services, 410 IAC 15-1.5-10, Utilization review & Discharge planning, 410 IAC 15-1.5-6, Nursing service, and 410 IAC 15-1.5-8, Physical plant, Indiana Hospital Licensure Rules. QA: claughlin 11/02/12	S 000		